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Major Sources of Public Funding of Maternity Services for Low-Income Pregnant Women and Adolescents

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ABSTRACT

Through expansions of Medicaid coverage since the 1980s and increased funding for other programs, Congress has shown a continued interest in improving access to maternity services for low-income populations. Most recently two bills were introduced to expand eligibility and services for pregnant women under the State Children's Health Insurance Program (H.R. 827) and Medicaid (H.R. 301). This report provides background information on eligibility requirements, enrollment trends and maternity-related benefits for seven federally supported programs that provide direct services or access to maternity care for the poor — Medicaid, State Children's Health Insurance Program, Indian Health Service, Substance Abuse Prevention and Treatment Block Grant, Health Centers program, Maternal and Child Health Block Grant, and the Healthy Start Initiative. This report also provides contextual information on the population of women of childbearing age, including statistics on overall poverty status, health insurance coverage by income level, birth-related data, and information on the receipt of prenatal care. This product will be updated as legislative action warrants.

Major Sources of Public Funding of Maternity Services for Low-Income Pregnant Women and Adolescents

Summary

In 1997, there were 60 million women of childbearing age in the U.S., of which 9 million were adolescents. Nearly 40% of women with incomes below the federal poverty level (FPL) were uninsured, as were roughly one-third of women with incomes between 100-199% FPL. In 1996, there were 3.9 million live births, nearly 13% to adolescent mothers.

Through expansions of Medicaid coverage since the 1980s and increased funding for other programs, Congress has shown a continued interest in improving access to maternity services for poor pregnant women and adolescents. During the 1st session of the 106th Congress, a bill was introduced to expand the State Children's Health Insurance Program (S-CHIP) to include optional coverage of low-income, uninsured pregnant women (H.R. 827). A separate bill would phase-in mandatory coverage of pregnant women and infants up to 185% FPL under Medicaid (H.R. 301). Current Medicaid law requires such coverage up to 133% FPL.

CRS identified seven federally supported programs that provide access to maternity services for low-income pregnant women and adolescents. By far, the two largest programs are Medicaid with funding estimated at $108 billion in FY1999, and S-CHIP with authorized spending set at $4.3 billion in FY1999. In both cases, the proportion of total funding devoted to services for pregnant women and adolescents is unknown. Medicaid paid for nearly 40% of live births in 1994 and 1995. There is some evidence that Medicaid and S-CHIP may be underutilized by current eligibles. Medicaid caseloads among children and adults are declining despite continuing expansions of Medicaid eligibility. CBO estimated that federal S-CHIP spending will total approximately $100 million for FY1998 and $800 million for FY1999, considerably below authorization levels for both years. Rules governing federal matching rates for outreach and education under both programs have been identified as potential obstacles to successful enrollment.

The remaining five federal programs identified for this report are substantially smaller than Medicaid and S-CHIP in terms of annual levels of funding. In decreasing order of FY1999 funding levels, these programs are the Indian Health Service ($2.2 billion), the Substance Abuse Prevention and Treatment Block Grant ($1.6 billion), the Health Centers program ($925 million), the Maternal and Child Health Block Grant ($700 million), and the Healthy Start Initiative ($105 million). Each of these programs serve selected, subgroups of low-income populations in community-based delivery systems throughout the country. The number of low-income pregnant women served by these programs and related expenditures are generally unknown. These five programs function in part as safety net providers for low-income, uninsured populations. They also utilize available insurance such as Medicaid (and eventually S-CHIP) to finance the costs of care to covered subgroups. However, data are not available to determine how efficiently and effectively funds across all seven federal programs described in this report are distributed and utilized to provide maternity care to the maximum number of low-income, pregnant women and adolescents.

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Overview

Access to maternity services for low income populations continues to be of interest to Congress as evidenced by past and recent legislation that provides federal support for a variety of insurance or direct service programs under which prenatal care, hospitalization for childbirth, and postpartum services for the poor are available. Recently, two bills were introduced in the House to expand eligibility and services for pregnant women under the State Children's Health Insurance Program (S-CHIP) and Medicaid.

Currently, there is little information regarding the breadth and depth of federal support for maternity care, including an understanding of how these programs overlap and interact to serve poor pregnant women and adolescents. To address these data needs, this report is divided into several sections. First, we provide general background information on the population of women of childbearing age and statistics on overall poverty status and health insurance coverage by income level. Next, key birth-related data is summarized, including information on the receipt of prenatal care. Then we turn to a description of major, federally supported health care programs that provide direct services or access to maternity services for the low-income population. Finally, we discuss current outreach, enrollment and coordination issues for these programs.

Background

Women of Childbearing Age[1]

In 1997, the total population of the United States was approximately 268 million. Women of childbearing age — females between the ages of 15 and 44 years — totaled roughly 60 million representing about one in five U.S. residents (22%). Nine million women of childbearing age (15.5%) were adolescents ages 15 to 19 years.

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[1] Calculations performed by CRS and based on data in Table No. 14, *Statistical Abstract of the United States: 1998*.

Poverty Status and Health Insurance Coverage Among Women of Childbearing Age

Access to health care, including maternity services for women of childbearing age, is often influenced by the presence of health insurance. Overall, in 1997, young adult women ages 19-29 years were more likely to be uninsured (25%) than adolescents (19%) or older females ages 30-44 years (16%).[2] Rates of insurance improve with increasing income, but this general age/insurance relationship was evident within all but the poorest subgroup of women of childbearing age. As shown in **Table 1**, among those with incomes below the federal poverty level (FPL), nearly 40% were uninsured, regardless of age. Among the near poor population of women of childbearing age (those with incomes between 100-199% FPL), 36% of the 19-29 age group lacked insurance compared to 31-32% of adolescents and older females. Similarly, within the non-poor population (incomes at or above 200% FPL), 17% of women ages 19-29 years did not have health insurance compared to 9-10% of younger and older women.

Among those with incomes below the federal poverty level, there was very little variation in the type of insurance coverage across age groups. Over one-third of poor women of childbearing age had Medicaid. Adolescents were somewhat more likely to be enrolled in Medicaid than older females (39 versus 35-36%, respectively). Finally, 25% of poor women ages 19-29 years had private insurance, slightly higher than the proportion of privately insured, poor adolescents and older females (21%).

Type of insurance coverage (Medicaid versus private insurance) differed considerably between poor and near poor women. While poor women of all ages were more likely to have Medicaid than private insurance (36% versus 22%), the opposite was true among near poor women (11% with Medicaid versus 54% with private insurance). Within the near poor population of women, 18% of adolescents had Medicaid compared to only 8-11% of older females. Private insurance coverage was more likely with increasing age among the near poor — 49% among adolescents, 52% among those aged 19 to 29 years, and 57% among the 30 to 44 age group.

The vast majority of non-poor women of childbearing age (income at or above 200% FPL) had private insurance, ranging from a low of 80% among the 19-29 age group to a high of 88-89% among adolescents and older females.

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[2] Calculations performed by CRS using the March 1998 Current Population Survey.

Birth-Related Statistics[3]

Table 2 provides recent, state-specific data on crude birth rates and the percentage of live births to adolescents. (Published data are not available for low-income pregnant women as a separate group.)

In 1996, there were 3.9 million live births in the United States resulting in an overall, crude birth rate of 14.8 per 1,000 population. The comparable figure across states ranged from 11.1 in Maine to 20.7 in Utah. Nationally, nearly 13% of all live births were among adolescent mothers, but this percentage varied widely among the states ranging from 7.3% in Massachusetts to 21.3% in Mississippi.

Table 3 provides additional information on fertility rates[4] by age for 1996. Overall, the U.S. fertility rate was 65.7 per 1,000 women of all ages. Females at the extremes of the typical childbearing period — those 15 to 17 years and 40 to 44 years — had the lowest fertility rates at 34.0 and 35.4, respectively. The highest fertility rates were observed among women in their twenties, at 111.1 births per 1,000 females aged 20 to 24 and 113.9 for those aged 25 to 29. Compared to 1996, fertility rates among adolescents have declined since 1991, a reversal of trends in the late 1980s. In contrast, similar rates for adults have risen over time (data not shown).

Receipt of Prenatal Care

Prenatal care is one of many factors believed to enhance newborn health. The Healthy People 2000 goal is for 90% or more of pregnant women to begin prenatal care in the first 3 months of pregnancy. **Table 4** displays national data on the timing of the initiation of prenatal care by age for 1991-1995. (Similar published data are not available for low income pregnant women nor for states separately.) There was a positive relationship between age and early initiation of prenatal care. Adult pregnant women ages 25 and above were already meeting the Healthy People 2000 goal in the early 1990s. The data are less clear for women ages 20-24 years because of the way in which the data are grouped. However, pregnant adolescents were clearly not meeting this goal. In fact, 14% of adolescents received late or no prenatal care.

Public Programs for Maternity Care for Low-Income Pregnant Women

There are seven major federally supported public programs that we have identified as providing access to maternity services for certain, low-income pregnant

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[3] Birth-related data are taken from the (a) *Monthly Vital Statistics Report* (v. 46, no. 1, supplement 2, September 11, 1997) as tabulated by the Centers for Disease Control and Prevention/National Center for Health Statistics and (b) the National Center for Health Statistics. *Health, United States, 1998 With Socioeconomic Status and Health Chartbook*, Hyattsville, MD: 1998, as cited in the *NIHCM Health Care System Datasource*, Second Edition, Washington, DC, National Institute for Health Care Management, 1999.

[4] Fertility rates = births per 1,000 women in a specified age group.

women. The two largest programs relevant to this analysis are Medicaid and the State Children's Health Insurance Program (S-CHIP). Other smaller, but still major programs include the Indian Health Service, the Substance Abuse Prevention and Treatment Block Grant, the Health Centers program, the Maternal and Child Health Block Grant (Title V), and the Healthy Start Initiative. Each is discussed in turn below.

Medicaid

Medicaid is a federal-state matching entitlement program providing medical assistance to low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children. Within federal guidelines, states have broad discretion in designing and administering their Medicaid programs. In 1994 and 1995, Medicaid paid for nearly 40% of the live births in the United States.[5]

The FY1999 budget estimate for Medicaid contained in the recently passed Omnibus Appropriations Bill for FY1999 (P.L. 105-277) was nearly $108 billion. In 1996, there were approximately 41 million Medicaid beneficiaries of which 52% were children, 22% were adults, 16% were blind/disabled, and 10% were aged.[6]

Persons qualifying for Medicaid must meet certain financial (income and resources) and non-financial (categorical, immigration status, and residency) criteria that vary considerably across states. In this memorandum, we focus our analysis on general, major eligibility rules most likely to affect enrollment of pregnant women and adolescents.[7]

AFDC-related Groups under Medicaid. Medicaid eligibility for AFDC (Aid to Families with Dependent Children)-related groups was affected significantly by both the Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA, P.L. 104-193), which replaced the AFDC cash assistance program with the Temporary Assistance for Needy Families (TANF) block grant program, and the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). For AFDC-related families, the net effect of these two laws is:

- For *new eligibles*, states must use AFDC income and resource standards in effect on July 16, 1996.

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[5] MCH Update: *State Medicaid Coverage of Pregnant Women and Children*, National Governors Association, September, 1997.

[6] See, Schneider, A., K. Fennel, and P. Long. *Medicaid Eligibility for Families and Children*. Washington, DC, Kaiser Commission on Medicaid and the Uninsured, September, 1998.

[7] We do not discuss eligibility as it applies to aged, blind or disabled individuals, or to aliens. However, it is important to acknowledge that some pregnant Medicaid enrollees may be classified as such.

- Families meeting AFDC eligibility criteria prior to PRWORA[8] *remain eligible* for Medicaid.

States may modify their rules governing income and resource standards for AFDC-related groups.[9] Transitional or extended benefits are available to families who lose Medicaid eligibility due to increased earnings or child support payments. Pregnant women who are not heads of households and children are exempt from TANF work requirements and retain their Medicaid eligibility. States have the option of continuing Medicaid eligibility for current child beneficiaries for up to 12 months without a redetermination of eligibility. States are also allowed to extend Medicaid coverage to children under 19 years of age on the basis of "presumptive" eligibility until formal determinations are completed.

For all AFDC-related groups, state Medicaid programs must provide prenatal, delivery and postpartum services.

Poverty-related Pregnant Women and Children under Medicaid. A number of laws were passed in the 1980s and early 1990s that extended Medicaid to certain groups of pregnant women and children not receiving cash assistance through the AFDC program who met financial criteria tied to specific percentages of the federal poverty level.[10] Currently, states are required to cover pregnant women and children under age 6 with family incomes below 133% FPL. Coverage for pregnant women is limited to services related to the pregnancy and complications of pregnancy. Eligibility for these women extends to 60 days after termination of the pregnancy. Poverty-related children receive full Medicaid benefits.

States are also required to phase in coverage of all children under age 19, who were born after September 30, 1983, and whose family income is at or below 100% FPL. The 1983 start date means that the age of mandatory coverage increases each year reaching age 18 in FY2002. In 1998, states covered poor children through 14 years of age.

States have the option to extend Medicaid to pregnant women and infants under age 1 not otherwise eligible whose family income is no more than 185% FPL. Finally, states have other options for further expanding eligibility to higher income groups, including waivers of federal rules.

Medically Needy Groups under Medicaid. To qualify for Medicaid through medically needy provisions, individuals must meet the non-financial standards, but not the income and resource requirements for AFDC-related eligibility. States may

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[8] For a detailed description of the AFDC-related groups covered under Medicaid prior to PRWORA, see the *1998 Green Book*.

[9] Such modifications can be made by raising income/resource standards up to the percentage increase of the Consumer Price Index after July 16, 1996, or by lowering income standards to applicable levels no lower than those in effect on May 1, 1988, or by using income/resource methodologies that are less restrictive than those in effect on July 16, 1996.

[10] In 1998, the poverty guideline in the 48 contiguous states and the District of Columbia was $16,450 for a family of four.

establish higher income or resource standards for the medically needy. Under medically needy programs, individuals may also "spend down" to the medically needy income and resource standards by incurring medical expenses to reduce assets and income below the financial standards. Medically needy programs are an option for states.

A state may set its separate medically needy income standard for a family of a given size at any level up to 133% of the maximum payment for a similar family under the state's AFDC program in place on July 16, 1996. States may limit the groups eligible for medically needy coverage. But if states implement a medically needy program, they must include all children under 18 who would qualify under one of the mandatory categorically needy groups, and all pregnant women who would qualify under either a mandatory or optional group, if their income or resources are lower. States with medically needy programs must provide prenatal and delivery services to medically needy pregnant women.

State-specific Medicaid Income Criteria and Overall Enrollment Patterns. **Table 5** displays Medicaid income eligibility criteria as a percentage of the federal poverty level. For both AFDC-related and medically needy groups, income standards are often well below poverty guidelines. Alabama has the lowest AFDC-related income criterion at 15% FPL and Connecticut has the highest level at 81% FPL.

Thirty-four states had medically needy programs in 1996. The lowest income eligibility criterion was 23% FPL for Tennessee while the highest standard was 86% FPL for California. For 28 of 34 states with medically needy programs, the medically needy income criterion was the same as or exceeded the AFDC-related income standard.

As of May 1998,[11] 20 states covered pregnant women under Medicaid with family incomes ranging from 133% FPL (the mandatory minimum) to 160%FPL. An additional 23 states extended Medicaid to pregnant women with incomes up to 185% FPL. Finally, seven states utilized income criteria ranging from 200-400%FPL.

For children between the ages of 6 and 14 years, most states expanded coverage to the minimum required income level of 100% FPL only. Nineteen states went above this standard, typically in line with income standards for children under 6 years (data not shown).

Prior to full phase-in of mandatory coverage, minimum income levels for Medicaid eligibility for most older, low-income adolescents (ages 14 to 19 years in 1998) are tied to AFDC-related standards in effect as of July 16, 1996. States can exceed these minimums at their option. For example, states can use less restrictive methodologies for determining countable income as permitted under Section 1902(r)(2) of the Social Security Act. States may also choose to extend Medicaid coverage to adolescents at higher income levels through S-CHIP (more information

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[11] See Appendix Table 1 in Schneider, A., K. Fennel, and P. Long. *Medicaid Eligibility for Families and Children.* Washington, DC, Kaiser Commission on Medicaid and the Uninsured, September, 1998.

on this alternative is presented below). In 1998, 34 states went beyond minimum AFDC-related levels and extended Medicaid eligibility to children ages 15 to 19 years with family incomes at or above 100% FPL. Six of these states set income criteria at or above 200% FPL, matching income criteria for younger children.[12]

Published data are not available that show Medicaid enrollment figures specifically for women of childbearing age. In 1995, there were roughly 5.2 million male and female adolescent Medicaid enrollees representing 17.0% of the U.S. population of all individuals ages 11 to 18 years.[13] There were an additional 8.8 million male and female Medicaid enrollees between 19 and 44 years of age, representing 8.4% of the U.S. population in that age range. In FY1997, among the 40.3 million Medicaid enrollees, 59.8% were female, 9.8% were males and females between the ages of 15 and 20 years, and 23.5% were males and females ages 21 to 44 years.[14]

State Children's Health Insurance Program

Since the enactment of Medicaid in 1965, the State Children's Health Insurance Program (S-CHIP) represents the second largest federal effort to provide health insurance coverage to uninsured, low income children. The Balanced Budget Act of 1997 (P.L. 105-33) includes provisions establishing S-CHIP under a new Title XXI of the Social Security Act. Federal funding for FY1999 is authorized at the level of $4.3 billion.[15] The program began in October 1997 and is authorized through 2007. Total federal funding authorization for this 10-year program is set at $39.7 billion.

S-CHIP is targeted at uninsured children who live in families with income below twice the poverty line. Generally, states will be able to use S-CHIP funds to provide coverage through health insurance that meets specific standards for benefits and cost-sharing, or through their Medicaid programs, or through a combination of both. Under limited circumstances, states have the option to purchase a health benefits plan that is provided by a community-based health delivery system, or to purchase family coverage under a group health plan as long as it is cost effective to do so.[16]

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[12] See Schneider, A., K. Fennel, and P. Long. *Medicaid Eligibility for Families and Children.* Washington, DC, Kaiser Commission on Medicaid and the Uninsured, September 1998.

[13] See the *1998 Green Book* for a detailed breakdown of Medicaid enrollment by age and income for 1995, based on tabulations performed by CRS using the March 1996 Current Population Survey.

[14] Calculations performed by CRS based on published HCFA 2082 data.

[15] The FY1999 figure for S-CHIP includes the additional $32 million allotted to the territories in the recent Omnibus Appropriations Bill for FY1999 (P.L. 105-277).

[16] In the case of community-based health delivery systems, the cost of such coverage cannot be greater, on an average per child basis, than the cost of coverage that would otherwise be provided. In the case of family coverage, such an alternative must be cost-effective relative to the amounts paid to obtain comparable coverage only of the targeted low-income children, and it must not substitute for health insurance coverage that would be provided to such

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Each state is allotted funds from the total authorized amounts based on a combination of the number of low-income children and low-income, uninsured children in the state. Federal matching funds will be disbursed quarterly to each state with an approved child health assistance plan. Each state will receive, from the federal government, a certain percentage (the enhanced federal matching percentage) of the total amounts paid for child health assistance.[17]

Title XXI defines children targeted by the legislation as those who are not eligible for Medicaid or covered under a group health plan or other insurance. In addition, states may cover children in families with incomes that are either: (1) above the state's Medicaid financial eligibility standard but less than 200% of the federal poverty level, or (2) in states with Medicaid income levels for children already at or above 200% FPL, within 50 percentage points over the state's current Medicaid income eligibility limit for children.

Not all targeted low-income children will necessarily receive health coverage. The law does not establish an individual's entitlement to the benefits of S-CHIP programs. State participation is voluntary, but once a S-CHIP state plan has been submitted and approved, states are entitled to a pre-determined, annual federal allotment. Each state will have the flexibility to define the group of targeted low-income children who will become eligible for that state's program. Title XXI allows states to use the following characteristics in determining eligibility: geography, age, income and resources, residency, disability status, access to other health insurance and duration of eligibility for other health insurance.

States that choose to expand Medicaid to new eligibles under S-CHIP must provide the full range of mandatory Medicaid benefits, including maternity care, and all optional services specified in their state Medicaid Plans. Alternatively, states may choose any one of three other benefit options: (1) a benchmark benefit package, (2) benchmark equivalent coverage, or (3) any other health benefits plan that the Secretary determines will provide appropriate coverage for the targeted population of uninsured children. These three additional benefit options may include maternity care. However, apart from requiring coverage of inpatient and outpatient hospital services, and physicians' surgical and medical services, there is no specific language in the federal statute that requires provision of prenatal, delivery and postpartum services with these non-Medicaid benefit plan options.

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[16] (...continued)
children but for the purchase of family coverage.

[17] The enhanced FMAP is equal to the state's Medicaid federal medical assistance percentage increased by the number of percentage points that is equal to 30% multiplied by the number of percentage points by which the federal medical assistance percentage is less than 100%. Compared with Medicaid FMAPs, which range from 50% to 82%, the enhanced FMAP for S-CHIP will range from 65% to maximum ceiling of 85%.

Tables 6 and 7[18] show state-specific eligibility criteria, enrollment estimates, and inclusion of prenatal care as a covered benefit. As of January 24, 1999, 53 states and territories had submitted S-CHIP state plans to the Health Care Financing Administration. Of these 53 submitted plans, 50 have been approved. There are 29 Medicaid expansions,[19] 14 new or expanded separate state programs, and 10 programs that will combine a Medicaid expansion and a separate state program. Nine plan amendments have also been approved and nine others are under review currently.

Among the 39 states with Medicaid expansions (29 Medicaid only plus 10 combination programs), all but 4[20] include at least some adolescents over age 14 in these S-CHIP programs. Ten states[21] with Medicaid expansions for S-CHIP target exclusively (at least some) adolescents over age 14.

Under Medicaid in 1999, states must cover children ages 6 to 15 in families with incomes up to 100% FPL. The age of mandatory coverage increases each year until reaching age 18 in 2002. Most states with a Medicaid expansion for S-CHIP are taking advantage of the opportunity to cover older teens (15 to 18 years of age) in families with incomes up to 100% FPL (or often higher) *sooner* than required under Medicaid. In addition, these states will receive an enhanced federal match rate through S-CHIP to cover care provided to these older adolescents. A similar situation holds for S-CHIP Medicaid expansions for pregnant teens. That is, some states (e.g., Illinois and Oklahoma) are targeting pregnant adolescents for S-CHIP coverage at income levels at or above the optional 185% FPL provided under Medicaid.[22] In these cases too, an enhanced federal matching rate will apply.

In separate state S-CHIP programs, the upper income eligibility level is the same as, or more often higher than, the Medicaid income criteria for children in the same age range. Among the separate state only and combination programs, the upper income criteria ranges from 133% FPL to 300% FPL.

Given that pregnancy-related services are mandatory under Medicaid, S-CHIP Medicaid expansions must include coverage for prenatal, delivery and postpartum services. Thus, prenatal care will be provided as needed to eligible children in the 29 states implementing S-CHIP through Medicaid expansions only. For the 14 states with separate state programs only, 12 will provide prenatal care and two will not (North Carolina and Pennsylvania). All 10 states with combination programs indicate

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[18] **Table 6** displays S-CHIP data for approved state plans and amendments only. **Table 7** displays S-CHIP data for submitted but not approved state plans. In the text, results are summarized for both approved and submitted, but not yet approved plans.

[19] Two states with approved Medicaid expansions — Arkansas and West Virginia — will become combination programs if their currently submitted amendments adding separate state programs are approved.

[20] These four states include Hawaii, Minnesota, New Hampshire and West Virginia.

[21] These include Alabama, Arkansas, California, Connecticut, Florida, Kentucky, Michigan, Mississippi, Texas and Wisconsin.

[22] This situation also applies to California's separate state program.

that prenatal care is a covered benefit under both the Medicaid expansion and the separate state program.

Inclusion of family coverage under S-CHIP is relevant for this analysis since this option may create an opportunity to provide maternity care to adult females in eligible families. A state may cover families that include targeted low-income children if the state establishes to the satisfaction of the Secretary that the purchase of such coverage is cost effective when compared with the cost of covering only the targeted low-income children in the families involved, and will not substitute for other health insurance coverage.

Currently, only one state — Massachusetts — has an approved S-CHIP plan that includes such family coverage. Massachusetts will provide family coverage to adults through the employer-sponsored health insurance portion of its Family Assistance Plan. To complement their S-CHIP programs, other states (e.g., Missouri, Vermont and Wisconsin) have approved 1115 Medicaid waivers to extend Medicaid coverage to certain categories of poor adults such as working parents leaving welfare, mothers who otherwise would lose Medicaid after childbirth, and parents and other caretaker relatives of S-CHIP children.

Of all federally financed health programs that provide maternity care to pregnant adolescents and adults, Medicaid and S-CHIP are by far the largest in terms of funding levels and authorized spending, respectively. There are five other federally supported programs that exceed $100 million in annual funding that also provide maternity care to low-income women. These programs are described below.

Indian Health Service

A large federal program providing maternity care and other medical services to Native Americans is the Indian Health Service (IHS), administered by the Department of Health and Human Services. FY1999 federal funding for IHS totals to $2.2 billion. The proportion of these funds specifically for pregnant women or maternity services is not available.

There are no specific eligibility criteria for pregnant women. Persons eligible for IHS include those of Indian or Alaska Native descent who: (1) are members of a federally recognized Indian tribe; (2) reside within an IHS Health Service Delivery Area; or (3) are not members of a federally recognized tribe but are the natural minor children (18 years old or younger) of such a member and reside within an IHS Delivery Area. The program serves federal reservations, Indian communities in Oklahoma and California, and Indian, Eskimo, and Aleut communities in Alaska. In addition, under the Indian Health Care Improvement Act, the IHS contracts with urban Indian organizations operating at 34 sites in cities throughout the country to make health services more accessible to the urban Indian population.

The IHS provides a comprehensive range of health care services through a system of more than 500 direct health care delivery facilities, including 49 hospitals, more than 180 health centers, 8 school health centers and 307 health stations and satellite clinics and Alaska village clinics. The range of services include traditional inpatient and ambulatory care, and extensive preventive care, including prenatal care.

In additional to providing general health services, the program focuses on such special problems as maternal and child health, and fetal alcohol syndrome.

Data on the number of pregnant women served by IHS are not available. For calendar years 1992-1994, there were 100,199 live births for the IHS service area population.[23] The crude birth rate during this period was 25.7 per 1,000 people, compared to 15.5 per 1,000 persons for all races nationwide in 1993. The percentage of live births for which mothers initiated prenatal care in the first trimester was 63.6%.

Substance Abuse Prevention and Treatment (SAPT) Block Grant

The Substance Abuse Prevention and Treatment (SAPT) Block Grant, administered by the Center for Substance Abuse Treatment (CSAT) within the Substance Abuse and Mental Health Services Administration (SAMSHA), also serves low-income pregnant women. FY1999 funding for SAPT is $1.6 billion for all services. Data on the portion of these funds for pregnant women or maternity care is not available.

Like the IHS described above, SAPT grants do not carry with them specific eligibility criteria for pregnant women. However, programs serving injection drug abuse populations must give treatment preference in the following order: (1) pregnant injecting drug users; (2) pregnant substance abusers; (3) injecting drug users; and (4) all others.

States are required to spend not less than 5% of the grant, relative to the prior fiscal year (beginning in FY1992) to increase the availability of treatment services designed for pregnant women and women with dependent children. Under this provision, each entity providing treatment services through the block grant will, directly or through arrangements with other public or nonprofit private entities, make available prenatal care to women receiving treatment. States may not use grant funds to provide inpatient services, except when medically necessary for substance abuse treatment, and when such services cannot be provided in the community.

With respect to program participation, the SAPT block grant supports a publicly funded substance abuse treatment system serving 3.8 million clients. Data on pregnant women being serviced by the SAPT block grant are not available.

Health Centers Program

The Health Centers Program, administered by the Bureau of Primary Health Care, Health Resources and Services Administration (HRSA) is another large federal program through which maternity care is provided to low-income women. The Health Centers Consolidation Act of 1996 (P.L. 104-299) consolidated federal support for community health centers, migrant health centers, health centers for the homeless, and health centers for residents of public housing. FY1999 appropriations

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[23] U.S. Dept. of Health and Human Services. Indian Health Service. Office of Public Health. Division of Community and Environmental Health. Program Statistics Team. *Regional Differences in Indian Health*. 1997.

for the Health Centers program totals $925 million. Data on the proportion of these funds targeted to pregnant women or maternity care are not available.

Federal grants may be made to public or nonprofit private organizations to plan and develop, or operate health centers in communities or areas designated as medically underserved. The law authorizing the Health Centers program specifically mandates centers to provide prenatal care. Each health center is also required to provide: primary health services, including physician and nurse services; diagnostic laboratory and radiologic services; preventive services; emergency medical services; transportation services, preventive dental services; and pharmaceutical services.

In FY1997, 746 organizations received grants to provide health services at over 3,000 sites. In FY 1996 Health Center patients included approximately 250,000 pregnant women and 360,000 infants. In FY1997, approximately 4.1 million participants were children aged 0-19 years.

Maternal and Child Health Block Grant (Title V)

Low-income pregnant women may also receive maternity care through the Maternal and Child Health Services Block Grant or Title V, administered by the Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA). Appropriations for FY1999 total $700 million. The amount of funds spent specifically on pregnant women or maternity care is not available.

Title V provides health services to mothers and children, particularly those with low income or limited access to health services. Each state determines its own eligibility criteria. The purposes of the block grant include reducing infant mortality; reducing the incidence of preventable disease and handicapping conditions among children; and increasing the availability of prenatal, delivery, and postpartum care to low-income mothers. States are required to use 30% of their block grant for preventive and primary care services for children, 30% for services for children with special health care needs, and 40% at the states's discretion for services for either of these groups or for other appropriate maternal and child health activities. These services may include prenatal care, well-child care, immunizations, vision and hearing screening, dental care, family planning, inpatient services for children with special health care needs, screening for lead-based poisoning, or counseling services for parents of sudden infant death syndrome victims.

In FY1996, Title V served approximately 10.6 million children and adolescents, 1.9 million pregnant women, 2.7 million infants, and 1 million children with special health care needs.

Healthy Start Initiative

Among major federal programs that provide maternity care to low-income pregnant women, the Healthy Start Initiative, administered by the Maternal and Child Health Bureau of the Health Resources and Services Administration, is the smallest in terms of funding. FY1999 appropriations total $105 million. Data on specific amounts spent for pregnant women or maternity care are not available.

Healthy Start funding is provided to qualified, local or state health departments or other publicly supported entities in urban and rural communities with average annual infant mortality rates of 15.7 deaths or more per 1,000 live births. Eligible beneficiaries are service area residents, particularly women and infants.

Healthy Start grantees are expected to ensure access to a comprehensive package of family planning counseling, pregnancy testing, prenatal care, pediatric care for infants, and social services. Other services appropriate to a community's needs may include outreach, home visits, child care, transportation, dental care, nutrition counseling, mental health, and substance abuse services.

Phase I of the Healthy Start Initiative began in 1991 and provided grants to 15 urban and rural communities with exceptionally high infant mortality rates. The demonstration program is intended to fund new and innovative ways of delivering care to pregnant women and infants with the goal of reducing infant mortality. Seven special projects were provided 2-year grants in October 1994 to accelerate the implementation of innovative strategies.

Phase II began in September 1997 to support 62 urban and rural communities with infant mortality rates greater than 1.5 times the national average. Planning grants have been made to an additional 14 communities with severe needs for assistance for infant mortality reduction.

Data on the numbers of persons served through Healthy Start are not available.

Summary and Conclusions

In 1997, there were 60 million women of childbearing age in the United States, of which 9 million were adolescents. Young adult women ages 19-29 years were more likely to be uninsured (25%) than adolescents (19%) or older females ages 30-44 years (16%). Rates of insurance improve with increasing income, but this general age/insurance relationship was evident within all but the poorest subgroup of women of childbearing age. Nearly 40% of women with incomes below the federal poverty level were uninsured, as were roughly one-third of women with incomes between 100-199% FPL. Some of these women may in fact be eligible for but not enrolled in Medicaid or S-CHIP, and probably rely on federally supported, "safety net" programs and delivery systems for their medical care, including those reviewed for this report.

Medicaid and S-CHIP: Current Outreach and Enrollment Issues

In 1996, there were 3.9 million live births in the United States. Medicaid paid for nearly 40% of live births in 1994 and 1995. Fertility rates among adult women have risen over time. In contrast, similar rates for adolescents have declined since 1991, a reversal of trends in the late 1980s. Nonetheless, adolescents continue to be a group of particular concern. In 1996, 13% of all live births were to children ages 15 to 19 years. National data on the timing of the initiation of prenatal care show a positive, linear relationship between older maternal age and early receipt of such care. In the early 1990s, 14% of pregnant teenagers received late or no prenatal care.

For this report, we identified seven federally supported programs that provide access to maternity services for low-income pregnant women and adolescents. By far, the two largest programs are Medicaid with funding estimated at $108 billion in FY1999, and the State Children's Health Insurance Program (S-CHIP) with authorized spending set at $4.3 billion in FY1999. In 1996, there were 41 million Medicaid beneficiaries, of which nearly three-fourths were non-disabled children and adults. Official enrollment figures for S-CHIP are not available currently, and enrollment projections by states are changing over time. Recently, the National Governors Association reported that more than 828,000 previously uninsured children were enrolled in S-CHIP in its first year.[24] Overall, it has been estimated that there are 2.9 million uninsured children in families with incomes below 200% FPL who are eligible for S-CHIP.[25]

Taken together, Medicaid and S-CHIP have the potential to provide access to maternity care for a significant proportion of poor and near poor pregnant women and adolescents. The proportion of total current funding under both programs devoted to services for pregnant women and adolescents is unknown. There is some evidence and considerable speculation that both programs may be underutilized by current eligibles. Analyses of 1994-1997 national survey data indicate that 21 to 42% of all uninsured children under 18 years of age are eligible for Medicaid but not enrolled.[26] Similar figures for pregnant women over age 18 are not available.

Moreover, recent data also indicate that Medicaid caseloads are declining despite continuing expansions of Medicaid eligibility. Medicaid enrollment among children under age 15 fell from 15.5 million in 1995 to 15.1 million in 1996. Similarly, the number of adults aged 21 to 44 years dropped from 8.6 million to 8.2 million across this same time period. (Data for adolescents were not reported.)

Many point to the delinking of AFDC/TANF and Medicaid as one possible explanation for these enrollment patterns. Declining AFDC/TANF caseloads subsequent to PRWORA may be contributing to the reductions in Medicaid enrollment, even though loss of cash assistance should not result in the automatic loss of Medicaid. TANF exit studies do not directly assess reasons for the drop in Medicaid enrollment, but some of the contributing factors may include, for example, family members no longer being eligible for Medicaid, failure to identify eligible families, lack of awareness of the availability of continuing Medicaid coverage, and agency errors.[27]

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[24] See *Federal-State Concerns: States Enroll 828,000 Uninsured Children in First Year of CHIP Program, NGA Reports. Bureau of National Affair's Health Care Daily Report*, v. 4, no. 40, March 2, 1999.

[25] See Ullman, F., B. Bruen, and J. Holahan. *The State Children's Health Insurance Program: A Look at the Numbers.* Washington, DC, The Urban Institute, March 1998.

[26] See Lewis, K., M. Ellwood, and J. Czajka. *Counting the Uninsured: A Review of the Literature.* Washington, DC, The Urban Institute, June 1998.

[27] See, Greenberg, M. *Participation in Welfare and Medicaid Enrollment*. Washington, DC, Kaiser Commission on Medicaid and the Uninsured, September 1998. Another recent study (continued...)

Similar concerns about underutilization have been raised about the S-CHIP. Recently, CBO estimated that federal S-CHIP spending will total approximately $100 million for FY1998 and $800 million for FY1999. For both years, total annual federal authorization levels are $4.3 billion (including the increase in the authorized allotment to the territories specified in P.L. 105-277 for FY1999). In general, annual allotments for each state with an approved child health assistance plan will remain available for that state for a period of 3 years. Thus, at this point in time, it is too early to determine whether states will eventually claim their full FY1998 and FY1999 federal S-CHIP funding.

One key to successful enrollment of all potential eligibles for both Medicaid and S-CHIP is outreach and education. Medicaid does not have a specified limit on the proportion of program spending devoted to administrative activities such as outreach, although the federal matching rate for such administrative expenses is lower than that for direct services. For federal matching purposes under S-CHIP, there is a limit on spending for administrative expenses including outreach and education. This limit or cap in a given fiscal year is equal to 10% of the amount states actually draw down from their allotments to cover benefits under S-CHIP, as opposed to 10% of the authorization level. States have expressed concern over this cap and its effect on their ability to do comprehensive outreach to achieve enrollment goals, especially early in the program. However, analyses that identify specific problems associated with outreach funding under S-CHIP are not yet available.

The current law allows flexibility in seeking federal payments for expenditures associated with S-CHIP outreach. For the 39 states that will expand Medicaid, federal financial participation for related administrative and outreach expenditures may be claimed either through Medicaid or S-CHIP.[28] All states have the option to delay claiming of administrative expenses under S-CHIP to maximize federal payment. Delays of up to 2 years are permitted from the date of the expenditure for the service. This option is designed to allow states with low benefit expenditures in the early years of the program to receive payments for associated administrative expenses over time at the enhanced federal matching rate.

To supplement public financing, private funding has become available to help states implement new outreach initiatives targeted at children and adolescents. The Robert Wood Johnson Foundation has established a new grant program, called Covering Kids. This program will make available to all states a total of $47 million over 3 years, starting in 1999, to design and conduct outreach activities that identify and enroll eligible children into Medicaid and other programs such as S-CHIP; to

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[27] (...continued)
on this issue is Health Management Associates: *The Dynamics of Current Medicaid Enrollment Changes*. Washington, DC, Kaiser Commission on Medicaid and the Uninsured, October 1998.

[28] States electing to claim such expenses under S-CHIP must continue to do so until the 10% limit is reached or until the available S-CHIP allotment funds for a given fiscal year are exhausted. At that point, states may then begin to claim S-CHIP-related Title XIX administrative and outreach expenditures above the 10% cap under the Medicaid program at the applicable (lower) federal Medicaid matching percentage.

simplify enrollment processes; and to coordinate existing coverage programs for children. Grant awards in the range of $500,000 to $1 million per state are expected, depending on the size of the state, scope of activities proposed, and other criteria.

Proposed Changes in Eligibility and Outreach Funding for Medicaid and S-CHIP

Early in the first session of the 106th Congress, two bills were introduced in the House to expand S-SCHIP and Medicaid coverage to pregnant women at higher income levels than currently required. Both bills also include financial incentives to expand such coverage.

As described previously, states may provide family coverage through S-CHIP under very limited circumstances. Such coverage may create an opportunity to provide maternity care to adult females in eligible families. H.R. 827 would expand S-CHIP to allow coverage of selected low-income, uninsured pregnant women. Specifically, states which already cover poverty-related pregnant women up to 185% FPL under Medicaid would have the option to enroll additional pregnant women in S-CHIP whose family incomes fall between 185% FPL and the applicable state-specific upper income limit under S-CHIP.[29]

This bill would also amend Medicaid law to give states the option to use their enhanced S-CHIP FMAP for coverage of additional pregnant women under Medicaid. That is, states which already cover poverty-related pregnant women up to 185% FPL under Medicaid as of the date of enactment of this new provision may receive their corresponding enhanced S-CHIP FMAP for the subgroup whose incomes fall between 133% FPL and 185% FPL.

H.R. 827 also includes several provisions to facilitate outreach and enrollment, including for example: (1) the development and use of uniform application forms and coordinated enrollment processes for S-CHIP and Medicaid, and (2) financial incentives to promote appropriate enrollment, most notably the use of 3% of S-CHIP allocations at a 90% federal matching rate for enrollment and outreach activities.

Finally, under H.R. 827 S-CHIP benefits would be limited to pregnancy-related services (prenatal, delivery and postpartum care) and medical care for other conditions that may complicate pregnancy through the 60-day postpartum period. This benefit package mirrors that available to poverty-related pregnant women under Medicaid.

In a separate, but related bill (H.R. 301), phased-in mandatory Medicaid coverage of pregnant women and infants up to 185% FPL is proposed. Specifically, states that are not yet providing such coverage would be required to extend Medicaid eligibility to these groups with incomes up to 150% FPL by July 1, 1999, and up to

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[29] The upper limit for a state is defined by (1) a specified figure above the state's Medicaid financial eligibility standard for pregnant women but less than 200%, or (2) in states with income levels for pregnant women already at or above 200% FPL, within 50 percentage points over that current level.

185% FPL as of July 1, 2000. This bill also includes provisions that allow flexibility in the income methodology, prohibit application of resource tests, and permit the addition of prenatal and postpartum home visitation services as a benefit.

The President's Budget for FY2000 also includes three proposed changes to eligibility and outreach funding under Medicaid and S-CHIP relevant to this discussion. First, reversing a provision in PRWORA, Medicaid eligibility for pregnant, legal immigrants who entered the country after August 22, 1996 would be restored. Coverage for these individuals would be limited to prenatal, delivery and postpartum services. The 5-year budget impact of this proposal is estimated at $105 million (with no costs in FY2000). Second, states would be permitted to expand the use of a special $500 million Medicaid fund now aimed at outreach for children losing welfare, to also fund outreach to other children eligible for Medicaid and SCHIP. Although not specifically targeted to pregnant adolescents, this proposal could potentially bring more such individuals into these programs. An additional $40 million for FY2000 and $345 million over 5 years is requested for such outreach. Third, the President's Budget includes a proposal to remove outreach from the 10% cap on specific assistance and administrative expenses under S-CHIP. This proposal establishes a separate 3% additional outreach cap tied to benefit expenditures (not allotments as under H.R. 827). While there are no additional costs for FY2000, an additional $875 million in funding for outreach is proposed for FY2001-FY2004.

Coordination Among Seven Federal Programs Providing Maternity Services to Poor Women

The remaining five federal programs identified for this analysis are substantially smaller than Medicaid and smaller than S-CHIP in terms of annual levels of funding. In decreasing order of FY1999 funding levels, these programs are the Indian Health Service ($2.2 billion), the Substance Abuse Prevention and Treatment (SAPT) Block Grant ($1.6 billion), the Health Centers program ($925 million), the Maternal and Child Health Block Grant or Title V ($700 million), and the Healthy Start Initiative ($105 million). Each of these programs serve selected, subgroups of low-income populations in community-based delivery systems throughout the country. Accurate counts of the number of low-income pregnant women served by these programs and related expenditures are generally not available.

In addition to supplementing existing community-based health care delivery systems or creating new provider networks, these five programs function in part as safety net providers for low-income, uninsured populations. They can and do utilize available insurance such as Medicaid (and eventually S-CHIP) to finance the costs of care to covered subgroups. However, data are not available to determine how efficiently and effectively funds across all seven federal programs described in this report are distributed and utilized to provide maternity care to the maximum number of low-income, pregnant women and adolescents.

Table 1. Percentage Distribution of Women of Childbearing Age by Income Level (% FPL), Health Insurance Coverage[a] and Age Group, 1997

Income 0-99% FPL				
	Public			
Age group	Medicaid	Other	Private	Uninsured
15-18	39	2*	21	38
19-29	35	2*	25	39
30-44	36	4	21	39
Total	**36**	**3**	**22**	**39**
Income 100-199% FPL				
	Public			
Age group	Medicaid	Other	Private	Uninsured
15-18	18	1*	49	32
19-29	11	1*	52	36
30-44	8	3	57	31
Total	**11**	**2**	**54**	**33**
Income 200% and above FPL				
	Public			
Age group	Medicaid	Other	Private	Uninsured
15-18	2	1*	88	10
19-29	2	1*	80	17
30-44	1	1	89	9
Total	**1**	**1**	**86**	**11**

Source: Calculations performed by CRS using the March 1998 Current Population Survey.

*Percent value is based on a small sample of respondents and is subject to large sampling error.

[a] Some individuals are covered by more than one type of health insurance. Categorization was determined using a hierarchy in the following order: employer-based; private; Medicaid or Medicare; CHAMPUS or VA; other public. Public-Medicaid = Medicaid. Public-Other = Medicare, CHAMPUS, VA or other public. Private = employer-based or private.

Table 2. General Birth Related Statistics by State, 1996

State	Total births	Crude birth rate	% births to women under 20
United States	3,914,953	14.8	12.9
Alabama	61,477	14.4	18.3
Alaska	10,161	16.7	11.2
Arizona	79,590	18.0	15.0
Arkansas	36,418	14.5	19.8
California	539,789	16.9	12.0
Colorado	55,840	14.6	11.9
Connecticut	44,312	13.5	8.2
Delaware	10,243	14.1	13.7
District of Columbia	8,336	15.3	16.8
Florida	189,458	13.2	13.4
Georgia	114,848	15.6	15.9
Hawaii	18,334	15.5	10.3
Idaho	19,059	16.0	13.5
Illinois	184,369	15.6	12.7
Indiana	83,303	14.3	14.5
Iowa	37,120	13.0	11.0
Kansas	39,734	15.4	13.1
Kentucky	52,632	13.6	17.0
Louisiana	66,178	15.2	18.9
Maine	13,775	11.1	9.7
Maryland	69,696	13.7	10.3
Massachusetts	80,457	13.2	7.3
Michigan	137,471	14.3	12.2
Minnesota	63,779	13.7	8.5
Mississippi	41,662	15.3	21.3
Missouri	73,782	13.8	14.1
Montana	10,707	12.2	12.5
Nebraska	23,321	14.1	10.6
Nevada	26,034	16.2	13.3
New Hampshire	14,548	12.5	7.4
New Jersey	113,902	14.3	7.7
New Mexico	27,235	15.9	17.9
New York	271,458	14.9	9.2
North Carolina	105,741	14.4	15.0
North Dakota	8,358	13.0	9.6
Ohio	152,664	13.7	13.3
Oklahoma	46,209	14.0	17.2
Oregon	43,677	13.6	13.2
Pennsylvania	149,962	12.4	10.6
Rhode Island	12,514	12.6	10.1
South Carolina	50,807	13.7	16.8
South Dakota	10,475	14.3	11.5
Tennessee	73,779	13.9	16.8
Texas	327,163	17.1	16.2
Utah	41,388	20.7	10.6
Vermont	6,745	11.5	8.9
Virginia	92,400	13.8	11.0
Washington	79,959	14.5	11.3
West Virginia	20,704	11.3	17.2
Wisconsin	67,094	13.0	10.6
Wyoming	6,285	13.1	14.4

Source: *NIHCM Health Care System Data Source*, Second Edition. Washington, DC, National Institute for Health Care Management, 1999.

Note: Crude birth rate = births per 1,000 population.

Table 3. Births and Fertility Rates[a] by Age, United States, 1996 (preliminary)

Age group (in years)	Number	Rate
15-44[b]	3,914,953	65.7
15-19	494,272	54.7
15-17	186,762	34.0
18-19	307,509	86.5
20-24	951,247	111.1
25-29	1,078,411	113.9
30-34	904,329	84.5
35-39	400,810	35.4
40-44	71,663	6.8

Source: Ventura, S.J., K.D. Peters, J.A. Martin, and J.D. Maurer. *Births and Deaths: United States, 1996.* Monthly vital statistics report, v. 46, no. 1, supplement 2, Hyattsville, MD. National Center for Health Statistics. September 11, 1997.

Note: Data for 1996 are based on a continuous file of records received by states, representing 94% of all births in that year. Figures for 1996 are based on weighted data rounded to the nearest individual, so categories may not add to totals.

[a] Defined as births per 1,000 women in the specified age group except as noted in b.

[b] Number includes births to women of all ages. Fertility rate computed by relating total births, regardless of age of mother, to women aged 15-44 years.

Table 4. Pregnancies Ending in Live Birth to Women 15-44 Years Old, and Months Pregnant When Prenatal Care Began: 1991-1995

Characteristic	Number (1,000)	Percent distribution			
		Total	Months pregnant when prenatal care began		
			Less than 3 months	3-4 months	5 months or more or no prenatal care
All pregnancies[a]	17,052	100.0	88.1	5.4	6.6
Age at time of birth					
Under 20 years old	2,023	100.0	75.3	10.7	14.0
20-24 years old	4,388	100.0	84.5	7.3	8.2
25-29 years old	5,088	100.0	91.3	4.0	4.7
30-44 years old	5,553	100.0	92.5	3.1	4.3

Source: U.S. National Center for Health Statistics. *Fertility, Family Planning, and Women's Health: New data from the 1995 National Survey of Family Growth, Vital and Health Statistics*, series 23, no. 19, 1997, as cited in Table 114 in *Statistical Abstract of the United States: 1998*, September 15, 1998.

[a] Includes pregnancies with missing information on prenatal care or wantedness status.

Table 5. Medicaid Income Eligibility Criteria

(As % of federal poverty level for the applicable year)

States	Maximum AFDC Benefits (July 16, 1996)	Medically needy, 1996	Pregnant women, 1998 [a]	Children ages 6 to 14, 1998 [a, b]	Children ages 15 to 19, 1998 [a]
United States	45[c]	49	133	100	—
Alabama	15	n/a	133	100	100
Alaska	76	n/a	133	100	90
Arizona	32	n/a	140	100	30
Arkansas	19	25	133	200	200
California	56	86	200	100	100
Colorado	39	n/a	133	100	37
Connecticut	81	71	185	185	185
Delaware	31	n/a	185	100	100
District of Columbia	37	n/a	185	100	37
Florida	28	28	185	100	100
Georgia	39	35	185	100	100
Hawaii	57	57	185	100	100
Idaho	29	n/a	160	160	160
Illinois	35	45	200	130	133
Indiana	27	n/a	150	100	100
Iowa	39	52	185	100	37
Kansas	40	44	150	100	100
Kentucky	49	28	185	100	46
Louisiana	18	n/a	133	100	17
Maine	51	42	185	125	125
Maryland	34	40	185	185	33
Massachusetts	52	72	185	133	133
Michigan	45	52	185	150	150
Minnesota	49	66	275	275	275
Mississippi	34	n/a	185	100	32
Missouri	27	n/a	185	100	100
Montana	41	46	133	100	48
Nebraska	34	45	150	100	100
Nevada	32	n/a	133	100	31
New Hampshire	51	60	300	185	185
New Jersey	41	52	185	133	133
New Mexico	36	n/a	185	185	185
New York	61	76	185	100	51
North Carolina	50	34	185	100	100
North Dakota	40	47	133	100	100
Ohio	32	n/a	150	150	30
Oklahoma	28	42	185	185	185
Oregon	43	57	133	100	100
Pennsylvania	39	43	185	100	37
Rhode Island	51	69	250	250	250
South Carolina	18	n/a	185	150	150
South Dakota	47	n/a	133	100	100
Tennessee	54	23	400	400	400
Texas	17	25	185	100	17

States	Maximum AFDC Benefits (July 16, 1996)	Medically needy, 1996	Pregnant women, 1998 [a]	Children ages 6 to 14, 1998[a, b]	Children ages 15 to 19, 1998[a]
Utah	53	53	133	100	100
Vermont	59	81	200	225	225
Virginia	22	33	133	100	100
Washington	50	62	185	200	200
West Virginia	24	27	150	100	100
Wisconsin	48	64	185	100	45
Wyoming	55	n/a	133	100	52

Source: Appendix Table 1 in Schneider, A., K. Fennel, and P. Long. *Medicaid Eligibility for Families and Children.* Washington, DC, Kaiser Commission on Medicaid and the Uninsured, September, 1998.

Note: The 1998 federal poverty level for a family of three was $13,650; for Alaska $17,070 and Hawaii $15,700. The 1996 federal poverty level for a family for three was $12,980; for Alaska $16,220 and Hawaii $14,930.

N/A: no medically needy program.

[a] Criterion as of May 20, 1998.
[b] For each succeeding year beyond 1998, the upper age for this category increases by one. For example, in 1999, this group includes children ages 6 to 15 years.
[c] The United States figure represents the median maximum AFDC benefit level.

Table 6. S-CHIP Eligibility Criteria and Coverage of Prenatal Care, Approved State Plans and Amendments (As of 1/24/99)[a]

State (or other territory)	Program Start Date	Type of program, upper income level[b] and age criteria			Total Enrollment Estimate[c]	Prenatal Care Covered[d]
		Medicaid expansion (ME)	Separate state plan (SSP)	Combination		
States with approved plans:						
Alabama	2/1/97			100% 15-18 (ME)	36,000[e]	yes
Alabama Amendment	9/1/98			200% 15-18 (SSP)		
Alaska	3/1/99	200% 0-18			4,900[f]	yes
Arizona	11/1/98		150%[g] 0-18		50,000	yes
Arkansas	10/1/98	100% 15			3,600	yes
California [h]	3/1/98 (ME) 7/1/98 (SSP)			100% 15-18 (ME)	500,000	yes [i]
				200% 1-18 (SSP)		
				250% 0-12 months, preg. teens (SSP)		
California Amendment [j]	not available					

State (or other territory)	Program Start Date	Type of program, upper income level[b] and age criteria			Total Enrollment Estimate[c]	Prenatal Care Covered[d]
		Medicaid expansion (ME)	Separate state plan (SSP)	Combination		
Colorado	4/22/98 (fee for service) 6/1/98 (managed care)		185% 0-17		23,000	yes
Connecticut [k]	6/1/98 (enrollment) 7/1/98 (services)			185% 15-18 (ME)	15,000	yes
				300% 0-18 (SSP)		
Delaware	11/1/98		200% 0-18		10,500	yes
District of Columbia	10/1/98	200% 0-18			8,400	yes
Florida	4/1/98			100% 15-18 (ME)	175,000	yes
				185% 1-18 (SSP)		
Florida Amendment 1 of 2	7/1/98			200% 0-18 (SSP)		
Georgia	11/1/98		200% 0-18		58,000	yes
Hawaii [l]	1/3/00	185% 1-6			not available	yes

State (or other territory)	Program Start Date	Type of program, upper income level[b] and age criteria			Total Enrollment Estimate[c]	Prenatal Care Covered[d]
		Medicaid expansion (ME)	Separate state plan (SSP)	Combination		
Idaho	10/1/98	165% 0-18			5,000	yes
Idaho Amendment	Retroactive to 7/1/98	150% 0-18			not available	
Illinois	10/1/97	133% 6-18			40,000	yes
		200% infants 0-1 and preg. teens				
Indiana	7/1/98	150% 0-18			58,000	yes
Iowa	7/1/98	133% 6-18			16,000	yes
Kansas	1/1/99		200% 1-18		30,000	yes
Kentucky	7/1/98 (ME)			100% 14-18 (ME)	not available	yes
	7/1/99 (SSP)			200% 0-18 (SSP)		
Louisiana	11/1/98	133% 6-18			28,350 [m]	yes

State (or other territory)	Program Start Date	Type of program, upper income level[b] and age criteria			Total Enrollment Estimate[c]	Prenatal Care Covered[d]
		Medicaid expansion (ME)	Separate state plan (SSP)	Combination		
Maine	7/1/98 (ME)			150% 1-18(ME)	10,400	yes
	8/1/98 (SSP)			185% 1-18 (SSP)		
Maryland	7/1/98	200% 0-18			15,500	yes
Massachusetts [n]	10/1/97 (ME)			150% 1-18 (ME)	37,000	yes
	7/1/98 (SSP)			200% 0-18 (SSP)		
Michigan	7/1/98 (SSP)			200% 0-18 (SSP)	133,000	yes
Michigan Amendment	5/1/98 (ME)			150%[o] 16-18 (ME)		
Minnesota [p]	10/1/98	280% 0-2			20	yes
Mississippi (Phase I)	7/1/98	100% 15-18 (ME)			not available	yes

State (or other territory)	Program Start Date	Type of program, upper income level[b] and age criteria			Total Enrollment Estimate[c]	Prenatal Care Covered[d]
		Medicaid expansion (ME)	Separate state plan (SSP)	Combination		
Missouri [q]	9/1/98	200%[r] 0-18			90,000	yes
Missouri Amendment (1115 Medicaid Waiver)		185%-300%[s] 0-18				
Montana	1/1/99		150% 0-18		9,000	yes
Nebraska	5/1/98	100% 15-18			1,500	yes
Nebraska Amendment	9/1/98	185% 0-18				
Nevada	10/1/98		200% 0-18		44,000	yes
New Hampshire	5/1/98 (Phase I)			300% 0-1 (ME)	4,000	yes
	1/1/99 (Phase II)			300%[t] 1-18 (SSP)		
New Jersey [u, v]	2/1/98 (ME)			133% 6-18(ME)	102,000	yes
	3/1/98 (SSP)			200% 0-18 (SSP)		

State (or other territory)	Program Start Date	Type of program, upper income level[b] and age criteria			Total Enrollment Estimate[c]	Prenatal Care Covered[d]
		Medicaid expansion (ME)	Separate state plan (SSP)	Combination		
New Mexico	8/1/98	235% 0-18			5,000 [w]	yes
New Mexico (1115 Medicaid waiver)[x]	from 1/11/99 through 12/31/04	186%-235% 0-18				
New York	4/15/98		185% 0-18		360,000	yes
North Carolina	10/1/98		200% 0-18		35,000	no
North Carolina Amendment [y]						
North Dakota	9/1/98	100% 6-18			not available	yes
Ohio	1/1/98	150% 6-18			133,000	yes
Oklahoma	12/1/97	185% 0-17, preg. teens			71,000	yes
Oregon	7/1/98		170% 0-18		17,000	yes

State (or other territory)	Program Start Date	Type of program, upper income level[b] and age criteria			Total Enrollment Estimate[c]	Prenatal Care Covered[d]
		Medicaid expansion (ME)	Separate state plan (SSP)	Combination		
Pennsylvania	5/28/98		185% 1-16		63,000	no
			185-235% 0-5			
Pennsylvania Amendment [z]	6/17/98		200% 0-18		46,000 [aa]	
Puerto Rico	1/1/98	200%[bb] 0-18			20,000 [cc]	yes
Rhode Island	5/1/98	250% 8-18			3,000	yes
South Carolina	8/1/98	150% 1-18			75,000	yes
South Dakota	7/1/98	133% 6-18			7,400	yes
Texas	7/1/98	100% 15-18			58,000	yes
Utah	8/3/98		200% 0-18		21,000	yes
Vermont [dd]	10/19/98		300% 0-18		1,104 [ee]	yes

State (or other territory)	Program Start Date	Type of program, upper income level[b] and age criteria			Total Enrollment Estimate[c]	Prenatal Care Covered[d]
		Medicaid expansion (ME)	Separate state plan (SSP)	Combination		
Virginia	10/22/98		150%[ff] 0-18 185% 0-18		63,200[gg]	yes
Virgin Islands [hh]	4/1/98	$8,500.00 [ii] 0-18			not available	yes
West Virginia	7/1/98	150% 1-5			696	yes
Wisconsin	7/1/98	100% 15-18			2,000	yes
Wisconsin Phase II [jj]	Not Available	185% 0-18			23,000 [kk]	

Source: CRS analysis of submitted state plans.

[a] As of January 24, 1999, 53 states or territories submitted their plans, of those 50 are approved. There are 14 separate state plans, 29 Medicaid expansions, and 10 combination plans. Currently nine state plan amendments have been approved and nine are still under review.

[b] Upper income eligibility level is defined as a percent of the Federal Poverty level (FPL). In 1998, the FPL was $16,450 for a family of four.

[c] Data for the enrollment estimates comes from HCFA's "Children's Health Insurance Program (CHIP) Progress Report as of September 18, 1998." These estimates reflect *state*'s unreviewed estimates of enrollment upon full program implementation. Estimates not from this source are otherwise specified.

[d] For all states implementing a Medicaid Expansion only, coverage of prenatal care is mandatory; thus, this column is automatically set to "yes." All S-CHIP programs are required to cover inpatient and outpatient hospital services, and physicians' surgical and medical services. However there is no specific language in the law that requires provision of prenatal care under non-Medicaid plans. For states implementing either a Separate State Plan program or a Combination program, information about prenatal care coverage was taken from the S-CHIP state plans and amendments. In these cases, a "no response" means the state plan or amendment did not provide a response regarding prenatal care coverage. A "yes" response indicates the state plan or amendment includes language that clearly stipulates the state provides prenatal care. A "no" response indicates the state plan or amendment includes language that clearly stipulates that the state does not provide prenatal care.

[e] This number represents enrollment estimate totals for Phase I and Phase II of Alabama's state plan.

[f] State officials estimate the Alaska CHIP plan will cover 4,900 uninsured children by October of 2000.

[g] Arizona stated it will cover children up to 19 up to 150% of the FPL by October 1, 1997. By July 1, 1999 children up to age 19 will be covered up to 175% of FPL. By July 1, 2000, children up to age 19 will be covered up to 200% of the FPL.

[h] California will (1) expand its Medicaid program to include children age 15-18 with family incomes below 100% FPL; (2) expand its Access for Mothers and Infants (AIM) program to cover infants up to age 1 and pregnant adolescents with family incomes up to 250% FPL; and (3) expand its state Healthy Families program to cover children age 1-18 with family incomes from 100%-200% FPL.

[i] Access for Infant and Mothers Program is a public-private partnership program which offers credible health coverage to pregnant women with incomes between 200-300% FPL. In California's AIM program state funds are used to cover under-insured pregnant women of any age. No enhanced match Title XXI funds will be used for pregnant women over age 18.

[j] California submitted a state plan amendment on April 14, 1998, approved June 26, 1998. The purpose of this approved amendment is to bring the Healthy Families program eligibility criteria into compliance with the state's authorizing legislation by eliminating income deductions in determining eligibility. California will apply the income disregards required of federally means tested programs. The state will also continue to use the Medi-Cal income deductions at the lower level of eligibility determination to ensure that no child who would have been eligible for Medi-Cal is enrolled in Healthy Families. (This information comes from the "California Title XXI State Plan Amendment Summary" on file with HCFA.)

[k] Connecticut will (1) expand its Medicaid program to children age 15-18 with family income up to 185% FPL; and (2) provide coverage to children age 0-18 with family income up to 235% FPL under a separate state program (an income disregard of 65% will be utilized to effectively bring coverage up to 300% FPL).

[l] Hawaii intends to submit subsequent amendments to implement the second and third phases of their Title XXI plan. Eventually the state intends to cover children up to age 19 with families whose incomes are less than 200% FPL.

[m] Louisiana anticipates they will enroll 28,350 eligibles through their Title XXI Medicaid Expansion by June 30, 1998. This information was presented in Section 9.2 of Louisiana's state plan.

[n] With respect to family coverage, Massachusetts will provide assistance to adults through the employer-sponsored health insurance portion of the family assistance plan.

[o] The state plan amendment modifies Michigan's Children's Health Insurance Plan by including a Medicaid eligibility expansion to children 16 through 18 years of age up to 150% of the Federal Poverty level. The amendment also made modifications to MIChild by reducing the family premiums to $5.00 per month regardless of the number of children, eliminates all copays for MIChild covered services, requires final eligibility determinations to be made by state staff, and establishes a 12-month lock-in to the health plans with changes allowed in the first 30 days of enrollment for cause thereafter.

[p] Minnesota submitted an 1115 waiver of the Title XXI provisions on May 22, 1998. On July 17, 1998, the state's 1115 proposal was denied.

[q] Missouri will use its Title XXI funding to expand its Medicaid program to children up to age 18 with family income up to 200% FPL; Missouri will cover children with family incomes between 200% and 300% FPL at its regular Medicaid FMAP through a § 1115 Medicaid waiver. The § 1115 waiver allows the state to charge cost sharing payments to eligible families between 185-300% of the FPL with children age 0-19. The state plan amendment defines the cost sharing requirement.

[r] Title XXI funds will be used to expand health insurance coverage to infants (age 0-1) in families with incomes ranging from 186%-200% FPL, to children ages 0-5 in families with incomes ranging from 134%-200% FPL, and to children age 6-18 in families with incomes ranging from 100%-200% of the Federal Poverty Level.

[s] Missouri's amendment requires the following modifications necessary to its 1115 demonstration award project: requirement of a co-payment at the time of professional service for uninsured children with family income above 185% of the FPL; requires a co-payment at the time of professional service and co-payment for prescription(s) for children with family income above 225 % FPL and below 300% FPL; requires a monthly premium for the child/children of a family with income above 225% FPL and below 300% of the FPL; expands coverage to non-custodial parents with family income at or below 125% FPL; begins services for uninsured adults in February, 1999; reimburses for extended women's health services through fee-for-service in all geographic areas; establishes a waiting list for services for adults, at the state's discretion, when the enrolled adult population reaches 34,000 uninsured women losing their Medicaid eligibility and 66,000 other waiver eligible adults, which includes the additional 5,000 non-custodial parents; and covers services for the expansion populations 30 calendar days after the date an application is received.

[t] This income level reflects an eligibility level net of adjustments to gross income. To expand its coverage to 300% of poverty, the state will apply an income disregard to set aside certain types of income a family may possess.

[u] New Jersey has submitted two state plan amendments, 98-2-MA and 98-4-MA. Plan amendment 98-2 MA concerns expanded Title XIX coverage for children under age 19 who meet certain requirements pursuant to Section 4901 of the Balanced Budget Amendment of 1997. Sate plan amendment 98-2 MA is a Title XXI State Plan which targets low-income children whose family income exceeds 133% of the FPL pursuant to Title XXI.

[v] New Jersey will (1) expand its Medicaid program to include children age 15-18 with family incomes below 133% FPL; (2) provide coverage with no cost sharing to children age 1-18 with family incomes between 133% and 150% FPL under its NJ KidCare Plan B; and (3) provide "subsidized" coverage, requiring a $15 monthly premium, to children age 1-18 with family incomes between 150% and 200% FPL under its NJ KidCare Plan C.

[w] New Mexican state officials estimate they will enroll more than 5,000 children by September 30, 2000.

[x] It is specified in New Mexico's approved 1115 waiver that: existing waivers under the authority of Section 1915(b) will apply to the expansion population under this demonstration to the same extent as they apply to the existing Medicaid population; services available under the waiver may vary by geographic location, but the Medicaid state plan will be in effect in all political subdivisions of the state; the 1115 waiver enables the state to offer additional benefits that will not be available to Medicaid beneficiaries who are not enrolled in the waiver program; the state will be allowed to impose co-payments that are not nominal on children through age 18 with family incomes from 186% through 235% FPL.

[y] North Carolina's state plan amendment is a technical amendment to ensure that children previously participating in North Carolina's Caring Program are immediately eligible for S-CHIP. Health insurance provided through the Caring Program was terminated earlier this year. Normally the state's crowd-out provisions would require a 6 month waiting period with no health insurance coverage before the child would become eligible for health insurance coverage under S- CHIP.

[z] The PA amendment will eliminate the $5 co-payment for prescription drugs required under the original plan. The benefit package will remain the same.

[aa] State officials estimate that approval of Pennsylvania's amendment will enable the program to cover more than 46,000 children by September 1999. This is in addition to the 63,000 children expected to be covered under the state's initial plan, which was approved on May 28, 1998.

[bb] Upper eligibility limit is 200% of Puerto Rico's poverty level, which is $8,220 for a family of four.

[cc] Puerto Rico is providing coverage to a total of 20,000 children using state and federal CHIP funds. The Commonwealth is providing additional funds to cover a total of 165,411 children. These projected enrollments may be affected by changes to S-CHIP as defined in P.L. 105-277. P.L. 105-277 appropriates $32,000,000.00 in "new" funds for FY1999, and is to be distributed according to a prescribed allotment percentage for each territory.

[dd] Vermont's state plan was received March 16, 1998. The state withdrew its S-CHIP proposal 8/5/98. Vermont submitted a second proposal 11/6/98 approved 12/15/98. Vermont intends to extend coverage through a Medicaid expansion to uninsured and under-insured children in families with incomes at or below 300% of FPL. It would also extend coverage to uninsured adults with children living at home when family income is between 150 and 185% of FPL. The state intends to build on it 1115 demonstration, The Vermont Health Access Plan.

[ee] Vermont state officials project an enrollment estimate of 1,104 by the end of FY01.

[ff] Virginia's S-CHIP plan has two components. The first will serve children under age 19 with family incomes up to 150% FPL. The second phase will cover children under age 19 in families whose incomes are up to 185% FPL. The difference between the two components is, families with incomes between 150 and 185% of the FPL will have out-of-pocket costs imposed at a later date through an amendment to this plan. The start date for Phase two of Virginia's State Plan is currently unavailable.

[gg] In HCFA's "State Children's Health Insurance Program Title XXI Projects: November 2, 1998" they report the goal of Virginia's proposed S- CHIP program is the enrollment of 63,200 by June 30, 2001.

[hh] P.L. 105-277 authorizes $32,000,000 in "new" funds for FY1999. This funding is appropriated from the treasury and is to be distributed according to the prescribed allotment percentages for each of the territories.

[ii] The Virgin Islands has a capped Medicaid program that receives $5.2 million in federal dollars each year. Covered groups include the medically needy, and persons in families with an annual income less than $8,500. There is an income disregard of $1,800 for specified resources. The Virgin Islands plans to cover as many eligibles as possible with their federal Medicaid funds, then will spend their allocated CHIP funds, and finally will use territory funds to cover their eligible families.

[jj] Phase II of Wisconsin's State Children's Health Insurance program is an expansion of CHIP to include children in families incomes up to 185% FPL. DHHS also approved an 1115 Medicaid waiver to allow parents of CHIP participants to receive coverage.

[kk] The state estimates that 23,000 children should be enrolled during the second phase of the insurance program by October 2000.

Table 7. S-CHIP Eligibility Criteria and Coverage of Prenatal Care, Submitted but not Approved State Plans or Amendments (as of 1/24/99)[a]

State (or other territory)	Date Submitted	Type of program, upper income levels[b] and age criteria			Total Enrollment Estimate[c]	Prenatal Care[d]
		Medicaid expansion (ME)	Separate state plan (SSP)	Combination		
States with Submitted Plans:						
American Samoa[e, f]	1/14/99	income level and age criteria not available			not available	yes
Arkansas Amendment	12/4/98		200% 0-18		28,800[g]	yes
California Amendment #2 of 2[h]	1/8/99					
Florida Amendment #2 of 2[i]	12/2/98					
Guam	12/30/98	133% 0-18			2,756	yes
Illinois Amendment [j]	11/10/98	133-185% 1-18 200% preg. teens and infants			100,000	yes

State (or other territory)	Date Submitted	Type of program, upper income levels[b] and age criteria			Total Enrollment Estimate[c]	Prenatal Care[d]
		Medicaid expansion (ME)	Separate state plan (SSP)	Combination		
Mississippi (Phase II)	8/4/98	133% 6-18 (ME)			not available	yes
New Hampshire Amendment[k]	12/28/98					
New York Amendment	5/26/98[l]		222% 0-18		360,000	yes
Oklahoma Amendment	12/31/98	185% 0-18			not available	yes
Rhode Island Amendment	11/10/98	300%[m] 8-18			not available	yes
Tennessee	1/02/98	200% 0-18			68,000[n]	yes
West Virginia Amendment	12/21/98		150% 6-18		10,760	yes

Source: CRS analysis of submitted state plans.

[a] As of 1/24/99, 53 states or territories submitted their plans, of those 50 are approved. There are 14 separate state plans, 29 Medicaid expansions, and 10 combination plans. Currently nine state plan amendments have been approved and nine are still under review.

[b] Upper income eligibility level is defined as a percent of the Federal Poverty Level (FPL). In 1998, the FPL was $16,450 for a family of four.

[c] Data for the enrollment estimates comes from HCFA's "Children's Health Insurance Program (CHIP) Progress Report as of September 18, 1998." These estimates reflect *State*'s unreviewed estimates of enrollment upon full program implementation. Estimates not from this source are otherwise specified.

[d] For all states implementing a Medicaid Expansion only, coverage of prenatal care is mandatory; thus, this column is automatically set to "yes." All S-CHIP programs are required to cover inpatient and outpatient hospital services, and physicians' surgical and medical services. However there is no specific language in the law that requires provision of prenatal

care under non-Medicaid plans. For states implementing either a Separate State Plan program or a Combination program, information about prenatal care coverage was taken from the S-CHIP state plans and amendments. In these cases, a "no response" means the state plan or amendment did not provide a response regarding prenatal care coverage. A "yes" response indicates the state plan or amendment includes language that clearly stipulates the state provides prenatal care. A "no" response indicates the state plan or amendment includes language that clearly stipulates that the state does not provide prenatal care.

[e] American Samoa submitted a draft proposal 9/29/98 to expand their Medicaid Program. Their state plan was submitted to HCFA 1/14/99. Their intension is to use their CHIP funds primarily for dental services and medical transportation.

[f] P.L. 105-277 appropriates $32,000,000.00 in "new" funds for FY1999. This funding is appropriated from the Treasury and is to be distributed according to the prescribed allotment percentages for each of the territories.

[g] In the Arkansas state plan amendment submission, state officials estimate 28,800 will be enrolled in their program by September of 2000.

[h] California submitted a second state plan amendment. If approved, California will revise their state plan to increase the application reimbursement fee to $50.00 per successful application to the Healthy Families Program. The fee will be used to reimburse a variety of community organizations referred to as Enrolled Entities (EE), for outreach and assistance in applying to the Healthy Families program. EEs include schools, day care centers, community clinics, faith-based organizations, and local health departments. California also plans to amend its state plan to reflect its established practice of exempting from co-payments Indian children enrolled in the Healthy Families program who use Indian Health Service funded clinics.

[i] In their second State Plan Amendment, Florida proposes to add employer sponsored insurance to their CHIP program. If approved the amendment will allow employers that provide health insurance to submit their benefit packages for approval as a benchmark plan. This would enable working families to access insurance through their employers.

[j] Illinois State Plan Amendment will be a Medicaid look-alike package with a state sponsored rebate program that requires some cost sharing from families.

[k] If approved, New Hampshire's amendment makes modifications to its benefit's package to include: prescription drug coverage; inpatient and outpatient substance abuse treatment; and dental services.

[l] New York submitted an amendment on 3/27/98 that was denied by HCFA on 4/1/98. New York put in a request for reconsideration of their amendment on 5/26/98. In their amendment, New York seeks approval from a legislative court to draw Federal funding from a retroactive start date of October 1, 1997. Currently that request is on hold.

[m] If approved, the Rhode Island Amendment will expand benefits under Rhode Island's Title XXI program for uninsured children up to age 19 to 300% of the FPL. The expansion will be accomplished in two ways: (1) Using Section 2110 of Subtitle J of the Balanced Budget Act of 1997 to cover uninsured children up to age 8 up to 300% of the FPL; (2) Using income disregards to cover children aged 8 to 19 up to 300% of the FPL.

[n] Enrollment estimates for the state of Tennessee are provided by state health officials and reported to HCFA but were not presented in their state plan submission.